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FEEDBACK shares excerpts of reports sent by VA personnel to PSRS. Actual quotes appear in italics. Created by an agreement between NASA and the VA in May 2000, PSRS is a voluntary, confidential, and non-punitive reporting system. PSRS encourages VA personnel to describe safety issues from their firsthand experience and to contribute their information to PSRS.

THANK YOU!

Thank you for responding to our invitation (published in the last issue of FEEDBACK) to send reports to PSRS about BCMA events, close calls or safety concerns. Keep them coming!

Telling "Twins" Apart

Two PSRS reporters described situations of drug administration events associated with close similarity in drug names and in labeling/packaging. In May 2001, JCAHO issued a Sentinel Event Alert on look-alike, sound-alike drug names. Two months earlier the US Pharmacopeia released a list of over seven hundred confusing drug name sets. The first reporter had another set to add to this list:

◆ [An] *order was correctly entered for docetaxel (for metastatic breast cancer) but misread by* [the] *pharmacist as Doxil,* [a] *more commonly used chemotherapeutic agent at the hospital.*

Independent verification of accurate drug dispensing by another pharmacist was bypassed:

◆ *Second check by another pharmacist was not done.* [That person] *was out of pharmacy at the time and patient was waiting to receive prescribed medication.*

◆ *Both administering nurse and verifying nurse checked the order and dose and read as "OK"… The verifying nurse for a moment thought it was different but it was so close she thought it must be the same and let it go.*

The second pharmacist discovered the error shortly after the medication was given. The reporter summed up the event:

◆ *The similarity of the drugs was a contributing factor. However, failure to follow the entire process of verification led to bypassing barriers that were in place, that if followed would have prevented the administration of the wrong drug.*

Another PSRS report describes the challenge of differentiating between multidose vials of Haldol and Prolixin.

◆ *The packages and vial labels are the same color, very slight difference in shade, and print the same for both medications.*

A nursing leader took action to increase staff awareness:

◆ *The charge RN has placed numerous posters in the med rooms regarding the Haldol/Prolixin look-alike packages and vials. Many staff nurses have thanked the charge RN for the poster reminders, since they had drawn up the wrong meds and during the double-checking… caught the potential error.*

◆ *Near miss event… easily corrected with color design change to multidose vial* [by pharmaceutical manufacturer].

A Guessing Game

According to the Journal of the Medical Informatics Association (Sep-Oct 2001), physician satisfaction with computerized order entry systems is strongly correlated with the ability to perform tasks in a straightforward manner. A clinician described how lack of accurate formulary information in CPRS affects efficiency:

◆ *The CPRS program does show a formulary-type display of available medications including strengths; however, the facility pharmacy inventory does not always stock the dosages displayed in the CPRS program… Current drug prescribing process creates confusion because the clinician often does not know the strength of drugs currently available in the pharmacy. If the clinician does not know the strength, he cannot know with certainty the amount of drug to be issued.*

The reporter added that the lack of an updated formulary affects others in the system:

◆ *Usually the pharmacist will try to contact the clinician but if that cannot happen* [they] *will make the best decision* [they] *can. This often results in inadequate amounts of drug being issued, which leads to phone calls and extra trips back to clinic.*

Reading the Fine Print

Ongoing research examines methods of labeling and packaging medications to improve drug therapy compliance in older people, taking into account their functional limitations. Examples are found in Drugs & Aging (Jan 1998) and Ergonomics (March 2003). A PSRS reporter is equally concerned with helping veterans overcome these challenges:

◆ *Our patient population is primarily elderly and their vision is not always 100%. Our prescription bottles have writing that is very small and hard to read, even for those with good eyesight. Also, the ink print on the prescriptions sometimes wears off which makes it even more difficult to read.*

Other adverse outcomes for patients could include:

◆ *[Patients] may not be taking their medications correctly or even taking the correct medications.*

The reporter suggested:

◆ *Developing a labeling system that highlights the important information, using larger print and bolding certain parts of the label.*

◆ *Attach another label (i.e. flag the bottle) with a large print of the drug name only so patients would know which drug they have... This would at least make it easy for them to identify their medications.*

◆ *Cover labels with transparent tape to protect printing.*

Strong Things Come in Small Packages

A PSRS reporter detailed the outcome of a medication dispensing event:

◆ *Hospital pharmacy mailed out medication to the wrong patient. Recipient took medication and became toxic, requiring hospitalization and dialysis.*

The next time, the patient was prepared:

◆ *One month later, same pharmacy sends wrong medication to the same patient — who by now realizes not to trust the medications he is sent. He brings the incorrect medications to his primary doctor.*

A Drip In Time Could Have Saved Nine

As many as 50% of postoperative patients are undermedicated and suffer unrelieved pain, according to the American Society of PeriAnesthesia Nurses (Feb 2002). In the VA, the technologies of PCA (patient controlled analgesia), BCMA and CPRS can work together to maximize patient comfort. However, this depends upon effective communication and coordination, especially between departments.

A post-surgical ward nurse described to PSRS what happened when those systems did not talk to each other. Fifteen minutes after arrival from the recovery room, a patient summoned the nurse:

◆ *[The patient] called out to RN to say he was in "severe" pain. ("12/10"). After checking BCMA for PRN meds, I found he had no PRN pain meds ordered. I then checked patient orders in CPRS and saw that PCA morphine sulfate had been ordered for patient for post-op pain [an hour earlier].*

The nurse telephoned the physician, who ordered a morphine sulfate bolus to initiate immediate pain relief.

◆ *Patient given morphine sulfate IV push and PCA was initiated [two hours after order written]. OR and PACU should initiate PCA prior to transfer to floor for control of immediate post-op pain.*

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